K&K INSURANCE CANADA

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K&K Insurance Brokers, Inc. Canada

ATHLETE ACCIDENT CLAIM FORM

File your claim promptly. Failure to do so could result in a denial of coverage. Consult the policy for the time limits for reporting and filing a claim.

SECTION I TO BE COMPLETED BY CLAIMANT'S AND/OR PARENT(S)/GUARDIAN(S)

1. Name: Last: _____ First: _____ Init: _____
2. Date of birth: _____ Sex: ❑ Male ❑ Female
3. Home Address: Street: _____
   City: _____ Prov.: _____ Postal Code: _____
   Parent's phone number: _____ Claimant's phone number: _____
4. Date of accident: _____ Time of accident: _____ ❑ AM ❑ PM
   Nature of injury: _____ Describe exactly how accident happened: _____
   _____
5. Nature of activity during which the injury occurred (check all boxes which apply): ❑ Left ❑ Right

   Name of sport, if applicable: _____

   ❑ Intercollegiate sports ❑ Intramural sports ❑ During practice
   ❑ Club sports ❑ High school catastrophic ❑ During play
   ❑ Other activity (specify)_____ ❑ During conditioning ❑ During travel to or from the event

   Nature of Your Participation:

   ❑ Student ❑ Athletic participant ❑ Other (specify)_____

6. Student? ❑ Yes ❑ No If yes, please identify the school name: _____
7. Name, address and phone of physician who first treated you: _____
   _____
8. Have you had a similar injury in the past? ❑ Yes ❑ No If yes, describe and give dates: _____
   _____
9. Name, address and phone of physician who treated you for previous injury: _____
10. Are you covered by any other medical expense benefits plan? ❑ Yes ❑ No If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you: _____
    _____
    _____

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief, the information contained is complete and correct as herein given.

I understand that it is a crime for any person to intentionally attempt to defraud or knowingly facilitate a fraud against an insurer by submitting an application or filing a claim containing a false or deceptive statement(s). See remarks section on reverse side of this form.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance Group Canada, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

Date _____ Claimant/Parent/Guardian Signature _____

SECTION II TO BE COMPLETED BY THE INSURED

1. Name of claimant: Last:_____ First: _____ MI: _____
2. Insured location: _____ 3. Date of accident:_____
4. Sport: _____
5. Nature of injury:_____ 6. ❑ Left ❑ Right
7. Name of Insured: CANADIAN VOLLEYBALL ASSOCIATION (VOLLEYBALL CANADA)

_____

8. Name of provincial athletic association if applicable: _____
9. If this injury was a reinjury, was the athlete cleared to participate? ❑ Yes ❑ No
10. IF YES, please attach physician's statement indicating doctor's release to return to athletic participation.
11. I certify that all the foregoing statements and answers on this form are true and complete, and that this claim satisfies all criteria set forth in our ACCIDENT POLICY for proper consideration as a covered participant, covered activity and a covered condition, to the best of my knowledge and belief.

Signature of Authorized Representative: _____

Title:_____ Date: _____

Comments:_____

FAILURE TO COMPLETE THIS FORM IN FULL MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM

INSTRUCTIONS FOR COMPLETING THE ACCIDENT INSURANCE FORM TO THE INJURED PERSON/PARENT /GUARDIAN

To the injured person/parent/guardian:

Complete part II of this claim form. Attach current itemized physician, hospital, or other provider's bills for accident medical expenses as well as the primary carrier's explanation of benefit showing their payment and denial. These bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred, and the charges made. Please note: Claim forms will be returned if not fully completed and signed. Omission of vital information will cause a delay in claim processing.

SEND TO:

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Commercial Broker
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Bradley's INSURANCE
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